NEWTON DRIVE HEALTH CENTRE
Newton Drive
Blackpool
FY3 8NX
Tel: 01253 955717

Dr J S Murray Dr S G Gall Dr S J Green Dr D K Biyani Dr D R Fernandes
Practice Manager: Chris Casey

To ensure we can best care for your needs, this form **must** be completed in full.
Failure to complete all the information requested may result in a delay in your registration.
Please make sure you bring photographic I.D with you when returning the forms to the Practice, such as a driving licence. If you do not have photographic I.D, please provide two items showing your current address (dated within the last 3 months)

The information provided on this application will, in no way, discriminate against you being accepted on to our practice list.

Have you ever been registered at Newton Drive Health Centre? Yes ☐ No ☐

If yes, please provide approximate date and reason for leaving the Practice. This will allow us to link your past medical history to the new registration

Medication and Health Checks

If you are on regular medication or suffer from a chronic disease you will be made an appointment for a new patient health check, please bring a urine sample with you to this appointment.

It is practice policy not to issue any medication to patients prior to approval of their registration.

It is your responsibility to ensure that you have at least a 3-week supply of any regular medication prior to submitting your registration forms to us. You must also provide us with a repeat medication slip stating the medication you are on and the dose (these can be obtained from your pharmacy).

We will not accept your registration form if you do not bring this information with you.

Prescribing of controlled drugs

The Practice policy is not to prescribe the following drugs unless **you provide** written evidence from your previous G.P. Surgery as these drugs can be dangerous in long-term use.

Benzodiazepine/Sleeping tablets including: -

- Diazepam Temazepam Oxazepam Nitrazepam Lormetazepam Chlordiazepoxide Lorazepam Zopiclone Zolpidem

Morphine Derivatives including: -

- Dihydrocodeine Codeine Morphine Buprenorphine Fentanyl

**** Even with previous GP evidence you will be required to commit to a reduction strategy if your dose is above practice policy levels****
THIS IS NONE NEGOTIABLE

We do not prescribe Methadone, Diamorphine or Buprenorphine (Subutex) **at all.**

By signing this section of the application form you are agreeing to adhere to the policies set out by the Practice regarding the ongoing use of Controlled Drugs.

I understand and agree to the terms above.

I am: The Patient ☐ The Patients Representative ☐ - Details …….

Signature: ……. Date: ……

Print Name: …….

About you					
Your Contact Details					
Title:			Home Address:		
Surname:					
First Name:					
Previous Surname:			Post Code:		
Date of Birth:			What type of property do you live in? (*Please Tick)*		
			Live Alone		
Home Telephone:			Live with Others		
Mobile Telephone:			Live in a Residential Home		
Work Telephone:			Live in a Care/Nursing Home		
Email Address:			Homeless		

Have you ever been known by any other names? If so, please give details:			
Have you ever been a member of the armed forces / national service? If so, please give details:			
What is your occupation:			
What is your first language?		Do you require an interpreter?	

What Gender do you identify as?	
Is your gender the same as the one that was assigned to you at birth?	
(if no, please give details)	

Carers *A carer is someone who looks after a relative, child or friend who, because of old age, physical or learning disability or any other illness – including a mental illness, cannot manage without support.*			
Do you have a Carer?	Yes ☐ No ☐	Please give details:	
Are you a Carer?	Yes ☐ No ☐	Please give details:	

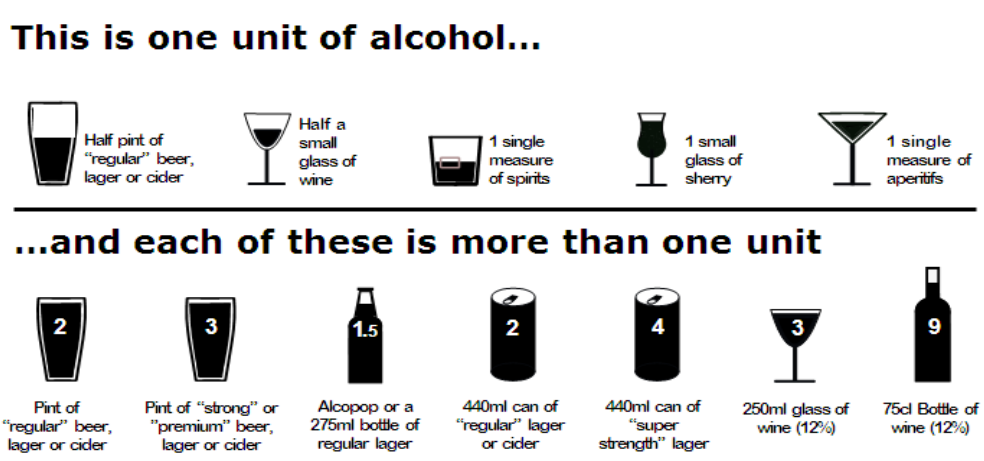
Next of kin: *By filling this section in you are consenting to this information being used or shared in the event of an emergency.*	
Name:	
Relationship to you:	
Address:	
Telephone Number:	

Do you hold a living will? *A living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness*	Yes ☐ No ☐
Do you have a Lasting Power of Attorney in place? *A lasting power of attorney is a legal document that lets you appoint one or more people to help you make decisions or to make decisions on your behalf.*	Yes ☐ No ☐
Do you have DNACPR in place? *This means 'Do not attempt cardiopulmonary resuscitation'.* *It means that if a person has a cardiac arrest or dies suddenly, there will be guidance on what action should or shouldn't be taken by a healthcare professional, including not performing CPR.*	Yes ☐ No ☐

Lifestyle			
Are you a smoker?	Yes ☐ No ☐ if yes, complete below		
If no, have you ever smoked?	Yes ☐ No ☐		
	☑		
Cigarette smoker:		How many Cigarettes do you smoke per day?	
Rolls own Cigarettes:		How many grams do you smoke per week?	
Pipe smoker:		How many grams do you smoke per week?	
Cigar smoker:		How many Cigars do you smoke per day?	
Electronic Cigarette smoker:			
For help and advice in stopping smoking please ask for a referral to the smoking cessation service			

Do you have an up-to-date Blood Pressure?	Yes ☐	No ☐	Value:	
Do you know your current weight?	Yes ☐	No ☐	Value:	kgs
Do you know your current height?	Yes ☐	No ☐	Value:	cm

Looking at the chart below, how many units of alcohol do you drink each week?	Units



Disabilities			
Do you consider yourself to have a disability?	Yes ☐ No ☐ if yes, complete below		
	☑		
Visual Disability:		Details:	
Hearing Disability:		Details:	
Wheelchair dependant:		Details:	
Speech problems:		Details:	
Other:		Details:	

Family Medical History
Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited diseases (attach a separate sheet if necessary)

Medical Information

As part of the registration process, you may be asked to attend for a new patient health check.
Please indicate below if you suffer from any of the following conditions

Epilepsy:	Yes ☐ No ☐		Blindness/Glaucoma:	Yes ☐ No ☐	
High Blood Pressure:	Yes ☐ No ☐		Diabetes:	Yes ☐ No ☐	
Heart Attack/Stroke:	Yes ☐ No ☐		Cancer:	Yes ☐ No ☐	
Asthma:	Yes ☐ No ☐		Depression:	Yes ☐ No ☐	
COPD:	Yes ☐ No ☐				

Are you allergic to any medication?	Yes ☐ No ☐ if yes, please give details below

Women's Health

Are you Pregnant?	Yes ☐ No ☐ if yes, how many weeks?	
Have you ever had a cervical smear?	Yes ☐ No ☐ N/A ☐ if yes, please state where and when	

Have you had a Hysterectomy (removal of womb)?	Yes ☐ No ☐
Have you had a Bilateral Oophorectomy (removal of ovaries)?	Yes ☐ No ☐
Have you ever had a Mastectomy (removal of breasts)? If yes, was it single or double mastectomy?	Yes ☐ No ☐ Single ☐ Double ☐

Electronic Prescription Service

Newton Drive Health Centre is able to send all prescriptions electronically through the Electronic Prescription Service (EPS).

If you have a preferred Pharmacy where you would like us to send your prescription, please list it here. If you do not nominate a Pharmacy, we will nominate one for you that is closest to your home address.

My nominated Pharmacy is:

Consent

Patient Access:

Patient access can be used for re-ordering repeat medication, booking routine GP appointments and some nurse appointments, and updating your personal information: address, telephone number etc. **By signing this registration form and providing us with proof of your ID we will automatically accept you for this service.**

For more information and details please go to our website: www.newtondrivehealthcentre.co.uk

Summary Care Records (SCR):

All patients have a Summary Care Record (SCR) unless you have chosen not to have one.

Your SCR contains the following basic information:

- Your name, address, date of birth and unique NHS Number which helps to identify you.
- the medicines you are taking and your allergies.

An SCR is used in a number of healthcare settings and will provide healthcare professionals with important information they wouldn't otherwise have. For example, when you're visiting an urgent care centre or being admitted to a hospital.

Reminder Text Messages and Phone Calls
The practice operates a call system where patients may be contacted to confirm the date and time of pre-booked routine appointments. By signing this registration form and providing us with your contact details you are giving us permission to contact you in this way unless you specify otherwise at the point of registration.
I agree that the information provided is accurate to the best of my knowledge and that I will adhere to the Newton Drive Health Centre Policies. Signature of Patient: ……. Date: …… Name of Patient: …….

For Reception/Admin Use only		
Date form received: …… Form received by: ……	Type of I.D seen: Driving Licence ☐ Passport ☐ Utility Bill (with current address on) ☐ NHS Smart Card / Work I.D ☐ Bank/Building Society Card ☐ Other Photo I.D ☐ Other ☐ ……	Date of New Patient Health Check: ……

NHS Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☐ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous GP practice while at that address

Address of previous GP practice

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

Postcode

Service or Personnel number: Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1.6km in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ Signature of Patient ☐ Signature on behalf of patient

Date_____/_____/_____

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:

White: ☐ British ☐ Irish ☐ Irish Traveller ☐ Traveller ☐ Gypsy/Romany ☐ Polish
☐ Any other white background (please write in):

Mixed: ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian
☐ Any other Mixed background (please write in):

Asian or Asian British: ☐ Indian ☐ Pakistani ☐ Bangladeshi
☐ Any other Asian background (please write in):

Black or Black British: ☐ Caribbean ☐ African ☐ Somali ☐ Nigerian
☐ Any other Black background (please write in):

Other ethnic group: ☐ Chinese ☐ Filipino
☐ Any other ethnic group (please write in):

Not stated: ☐
Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

NHS Family doctor services registration

GMS1

To be completed by the GP Practice

Practice Name

Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name Date _____/_____/_____

SUPPLEMENTARY QUESTIONS – These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		**Date:**	DD MM YY
Print name:		**Relationship to patient:**	
On behalf of:			

Complete this section if you live in an EU country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	**YES:** ☐ **NO:** ☐	If yes, please enter details from your EHIC or PRC below:
	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
PRC validity period (a) From:	DD MM YYYY	(b) To: DD MM YYYY

If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC)/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with Business Service Authority for the purpose of recovering your NHS costs from your home country.